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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DARLENE WEBBER** **aka DARLENE REESE BEDSTED** 474 Loyola Avenue Clovis, California 93619 **Registered Nurse License No. 461927** Respondent.	Case No. 2011-65 **ACCUSATION**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about March 31, 1991, the Board issued Registered Nurse License Number 461927 to Darlene Webber, also known as Darlene Reese Bedsted ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2012, unless renewed.

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STATUTORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

5. Code section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

REGULATORY PROVISIONS

6. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

8. "Vicodin" is a compound consisting of 5 mg. hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 500 mg. acetaminophen per tablet.

9. "Percocet," a brand of Oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(N).

EL CAMINO HOSPITAL

BACKGROUND INFORMATION

10. On or about April 18, 2004, Respondent was employed as a registered nurse in the labor and delivery unit at El Camino Hospital, located in Mountain View, California.

11. At about 1400 hours, a 34-year-old pregnant patient arrived with complaints of labor contractions. After examination, it was determined that the patient was in the first stage of labor. The patient wanted a natural childbirth, and did not want to be continuously monitored. However, the patient agreed to intermittent monitoring. The patient was accompanied by a doula and her husband.

12. At about 1510 hours, Respondent assumed care of the patient. At the time Respondent assumed care, there was about a 2 1/2 minute continuous fetal heart monitoring strip. However, the strip was not enough to evaluate the fetus. The fetal heart rate pattern became spotty. Respondent documented on the strip that she was picking up maternal heart tones while the patient was sitting in a chair. The patient got into bed and Respondent ran a strip for about 3 1/2 minutes. At the end of the 3 minutes, the fetal heart rate dropped into the 100's and then there appeared to be a brief five second segment at 155 bpm (beats per minute). This drop in the heart rate may have been a variable deceleration that is usually caused from cord compression, or it

could have been artifact from the patient getting out of bed. It is impossible to know which of the two it was. In addition, the length of the strip was not adequate to evaluate the fetus.

13. Between about 1522 hours and 1610 hours, the patient was in the bathroom and not being monitored.

14. At about 1612 hours, the patient's husband told Respondent that he believed the patient's water had broke. While Respondent was assisting the patient back to the bed from the bathroom, she noticed fluid on the floor. Respondent immediately examined the patient and confirmed that the patient's water had broke and that the patient was dilated to approximately 8-9 cm. Respondent notified the physician by telephone of the patient's condition and called the charge nurse for assistance. Respondent placed the fetal monitor back on patient, but the monitoring became difficult due to the patient's movements resulting from the pain of the contractions. Respondent heard the fetal heart rate going down with the contractions and not recovering fast enough. Respondent suggested to the patient that she place a fetal spiral electrode on the fetus' head for accurate monitoring, but the patient refused. Respondent then placed an oxygen mask on the patient's face and repositioned her. The charge nurse had the cesarean section room opened up, and Respondent called the nursery nurses and neonatal team into the room.

15. At about 1620 hours, the patient continued to refuse a fetal spiral electrode.

16. At about 1626 hours, the physician arrived and the patient began to push. Respondent told the physician that she was unable to get acceptable heart tones on the baby.

17. At about 1639 hours, the physician insisted that the patient allow placement of a fetal spiral electrode. The patient allowed the procedure.

18. At about 1641 hours, the physician inserted the fetal spiral electrode into the baby's head.

19. At about 1655 hours, the physician applied a vacuum extractor to the baby's head to aid in the delivery.

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20. At about 1709 hours the baby was delivered. The baby was limp and not breathing (bradycardia). The baby was intubated and taken to the neonatal intensive care unit. The baby was resuscitated but may have suffered brain damage.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

21. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that on or about April 18, 2004, while employed as a registered nurse at El Camino Hospital, located in Mountain View, California, she was incompetent in the following respects:

Failure to Accurately Assess Fetal Status

a. When the fetal heart rate dropped into the 100's, as more particularly set forth above in paragraph 12, Respondent failed to place the patient back on the fetal monitor to reassess the fetal heart rate pattern to help identify any problems.

b. Respondent failed to document the information that she provided to the patient regarding the risks of not allowing continuous monitoring of the fetal heart rate when there was a potential problem that could cause harm to the fetus.

Failure to Intervene

c. At 1612 hours, when Respondent noted that the fetal heart rate was going down with the contractions and not recovering fast enough (bradycardia), Respondent failed to start an IV to give the patient a fluid bolus.

Failure to Document Patient Status

d. Respondent failed to provide an accurate description of the patient's care, in that she failed to document the following:

i. What information was given to the patient regarding her refusal to allow proper monitoring of the fetus.

ii. What information was given to the physician when he called in for a status report.

iii. What pressure the vacuum extractor was used during the delivery of the baby.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

22. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that on or about April 18, 2004, while employed as a registered nurse at El Camino Hospital, located in Mountain View, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraph 21.

SAINT AGNES MEDICAL CENTER

THIRD CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

23. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that between November 15, 2007, and February 8, 2008, while a registered nurse at Saint Agnes Medical Center, located in Fresno, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient 1:

a. On or about November 15, 2007, at 1531 hours, Respondent signed out two (2) tablets of Oxycodone. Respondent charted the administration of two Oxycodone tablets on the patient's Medication Administration Record ("MAR") at 1229 hours and two tablets at 1531 hours. However, Respondent only signed out two tablets of Oxycodone. In addition, Respondent failed to chart the administration of Oxycodone in the nursing notes.

Patient 2:

b. On or about November 20, 2007, at 1334 hours, Respondent signed out two (2) tablets of Oxycodone. At 1356 hours, Respondent charted the administration of two Oxycodone tablets on the patient's MAR, but failed to chart the administration of the Oxycodone in the patient's nursing notes.

Patient 3:

c. On or about November 20, 2007, at 1629 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

d. On or about November 20, 2007, at 1716 hours, Respondent signed out two (2) tablets of Hydrocodone. At 1724 hours, Respondent charted the administration of two tablets of Hydrocodone on the patient's MAR, but failed to chart the administration of the Hydrocodone in the patient's nursing notes.

Patient 4:

e. On or about November 23, 2007, at 1610 and 1843 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 5:

f. On or about November 29, 2007, at 1246 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 6:

g. On or about December 4, 2007, at 1203 hours and 1205 hours, Respondent signed out one (1) tablet of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 7:

h. On or about December 4, 2007, at 1413 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 8:

i. On or about December 6, 2007, at 1239 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 9:

j. On or about December 10, 2007, at 1635 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 10:

k. On or about December 10, 2007, at 1751 hours, Respondent signed out two (2) tablets of Oxycodone without a physician's order, and failed to account for the Oxycodone in any hospital or patient record.

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Patient 11:

l. On or about December 13, 2007, at 1221 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 12:

m. On or about December 13, 2007, at 1438 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 13:

n. On or about December 13, 2007, at 1808 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 14:

o. On or about January 9, 2008, at 1343 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 15:

p. On or about January 17, 2008, at 1748 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record. Furthermore, the patient was discharged at 1745 hours.

Patient 16:

q. On or about January 21, 2008, at 1210 hours, Respondent signed out two (2) tablets of Oxycodone. At 1224 hours, Respondent charted the administration of two tablets of Oxycodone on the patient's MAR, but failed to chart the administration of the Oxycodone in the patient's nursing notes.

Patient 17:

r. On or about January 21, 2008, at 1820 hours, Respondent signed out two (2) tablets of Oxycodone. At 1823 hours, Respondent charted the administration of two tablets of Oxycodone on the patient's MAR, but failed to chart the administration of the Oxycodone in the patient's nursing notes.

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Patient 18:

s. On or about January 24, 2008, at 1224 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 19:

t. On or about January 24, 2008, at 1756 hours, Respondent signed out two (2) tablets of Oxycodone. Respondent charted the administration of two tablets of Oxycodone at 1706 hours, which is approximately fifty (50) minutes prior to her signing out the medication.

Patient 20:

u. On or about January 31, 2008, at 1152 hours, Respondent signed out two (2) tablets of Oxycodone. Respondent charted the administration of two tablets of Oxycodone at 0045 hours, which is approximately eleven (11) hours before she signed out the medication.

Patient 21:

v. On or about February 8, 2008, at 1152 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record.

Patient 22:

w. On or about February 8, 2008, at 1557 hours, Respondent signed out two (2) tablets of Oxycodone, but failed to account for the Oxycodone in any hospital or patient record. Furthermore, the patient was discharged at 1515 hours.

FOURTH CAUSE FOR DISCIPLINE

(Obtained, Possessed, and Self-Administered a Controlled Substance)

24. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(a), in that between 2007 and February 8, 2008, while a registered nurse at Saint Agnes Medical Center, located in Fresno, California, Respondent did the following:

a. Respondent obtained Oxycodone, a controlled substance, by fraud, deceit, misrepresentation or subterfuge or by the concealment of a material fact in violation of Health and Safety Code section 11173(a), by signing out Oxycodone for the administration to various patients, but taking it for her own personal use.

b. Respondent possessed Oxycodone, a controlled substance, in violation of Code section 4060, in that she did not have a prescription for that controlled substance.

c. Respondent self-administered Oxycodone, a controlled substance, without direction to do so from a licensed physician and surgeon, dentist or podiatrist.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 461927, issued to Darlene Webber, also known as Darlene Reese Bedsted;

2. Ordering Darleen Webber, also known as Darlene Reese Bedsted to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/19/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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